PRINTED: 12/10/2
FORM APPROV
OMB NO. 0938-0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 1/2/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445254	A. BUILDING _____ B. WING _____	12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA NURSING AND REHAB CENTER	18805 ALBERTA DR ONEIDA, TN 37841

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATI
F 000	INITIAL COMMENTS On December 7, 2010 the annual recertification survey and investigation of complaint #28815 was completed. No deficiencies were cited related to the complaint.	F 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F157	1) Residents # 5's Physician and responsible party was notified on 9/13/10 by the Assistant Director of Nursing. No adverse outcome noted. 2) Residents have the potential to be affected by the citation. No residents were identified to be affected by this. 3) An in-service on "Abuse Prevention and Event Management Policy and Procedure" for reporting events to the Physician and the responsible party, documentation requirements of notification and use of notification checklist was conducted by the Administrator and/or Director of Nursing for licensed nursing and certified nursing assistants on 12-5-10 and completed on 12-9-10. Licensed Nurse assigned to the resident will complete the notification checklist prior to leaving shift. The Director of Nursing implemented a notification checklist on 12-09-10 that will be completed on all events starting 12-14-10.	12/14/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angie Whitwood — TITLE: Administrator — (X6) 12/14/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determin other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclos days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to cont program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to timely notify the attending physician and responsible party of a fall for one resident (#5) of sixteen residents reviewed. The findings included: Resident #5 was originally admitted to the facility on November 30, 2004, and readmitted on September 22, 2010, with diagnoses including Cardiovascular Accident (Stroke), Renal Failure, Hemangioma, Congestive Heart Failure, Hypertension, Anemia, Anorexia, and Chronic Airway Obstruction. Medical record review of the facility investigative report and nurses notes revealed the resident experienced a fall without injury on September 10, 2010, at 4:20 p.m.; continued review revealed the resident's physician and responsible party was not notified of the fall until September 13, 2010. Observation on December 5, 2010, at 12:40 p.m., in the dining room, revealed the resident sitting in a wheelchair eating lunch and talking with another resident at the table. Interview with the Assistant Director of Nursing (ADON), and Director of Nursing (DON) in the DON's Office on December 7, 2010, at 8:50 a.m., confirmed the facility failed to notify the attending physician and responsible party of the resident's fall occurring on September 10, 2010, until September 13, 2010, (three days later).	F 157	4) The Director of Nursing or Registered Nurse will audit notification checklists for responsible party and physician notification on all events daily times 7 days then five times a week times 1 month then 3 times a week for 2 months and/ or 100% compliance. Results of this audit will be reviewed by the Quality Assurance Committee. Members of the committee are the Administrator, Director of Nursing, Medical Director, Human Resources, Rehab Director, Medical Records, Social Services, Dietary Manager, Minimum Data Set RN, and Activity Director.	

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to maintain an accurate and complete medical record for one resident (#4) of sixteen residents reviewed. The findings included: Resident #4 was admitted to the facility on November 30, 2004, with diagnoses including Alzheimer's Disease, Dementia, Paralysis Agitans (Parkinson's Disease), Schizoaffective, Affective Psychosis, Depressive Disorder, and Dysphagia. Review of dental records dated April 26, 2010, revealed "extract prn(as needed) #10 (upper front lateral)." Medical record review of the facility's quarterly dental assessments dated July 15, 2010, and October 8, 2010, revealed the resident to have	F 514	1) Resident #4 immediately had a dental assessment performed and documented by the Director of Nursing on 12/5/10. Results of the assessment were reported to the POA by the Social Service Director on 12/5/10 and to the physician by the Assistant Director of Nursing on 12/5/10. No adverse outcome noted. 2) All residents had dental assessments performed on 12/5/10 by the Director of Nursing, Assistant Director of Nursing and the Minimum Data Set Nurse. 3. An in-service was conducted by the Director of Nursing and /or Registered Nurse Supervisor for licensed nurses how to perform dental assessments and documentation requirements, and certified nursing assistants on reporting problems with teeth or dentures to the nurse for follow up assessment to be done and documented on 12-5-10 and completed on 12-9-10. 4) The Director of Nursing and/or Registered Nurse Supervisor will verify accuracy of all dental assessments weekly times 4 weeks then monthly times 3 months and/or 100% compliance. Results of audits will be reviewed at the Quality Assurance meeting. Members of the Quality Assurance Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Dietary Manager, Minimum Data Set RN, Medical Records, and Rehab Manager.	12/9/1

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F 514	Continued From page 3 three missing upper teeth (#1, #2, #16). Continued review of a Dental Assessment dated October 1, 2010, revealed the assessment of the upper teeth section to be blank. Observation of the resident's upper front teeth on December 5, 2010, at 2:00 p.m., in the resident's room, revealed tooth #10 (upper front lateral incisor) was broken at the gum line. Interview with the Licensed Practical Nurse (LPN) #1 on December 5, 2010, at 2:50 p.m., in the Director of Nursing's (DONs) office confirmed LPN #1 failed to complete the October 1, 2010, quarterly dental assessment of the resident's upper teeth. Interview with the Minimum Data Set (MDS) Coordinator on December 5, 2010, at 3:10 p.m., in the Director of Nursing's (DONs) office confirmed the MDS Coordinator completed the quarterly dental assessments dated July 15, 2010, and October 6, 2010, and did not recall a missing lateral incisor (#10 - upper front lateral). Telephone interview with the resident's dentist on December 6, 2010, at 10:00 a.m., confirmed the resident's lateral incisor - tooth #10 (upper front lateral) was broken at the gum line upon the initial visit with the resident on April 26, 2010. Continued interview with the dentist confirmed the tooth did not need extracting, "...unless the tooth was symptomatic (causing pain) it did not need to be extracted; tooth extraction in geriatric residents can have adverse side effects or be detrimental to the resident..."	F 514		